

Nebraska Public Power District

COOPER NUCLEAR STATION
P.O. BOX 98, BROWNVILLE, NEBRASKA 68321
TELEPHONE (402) 825-3811

CNSS790505

September 28, 1979

Mr. K. V. Seyfrit
U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region IV
611 Ryan Plaza
Suite 1000
Arlington, Texas 76011

Dear Sir:

This report is submitted in accordance with Section 6.7.2.B.1 of the Technical Specifications for Cooper Nuclear Station and discusses a reportable occurrence that was discovered on August 31, 1979. A licensee event report form is also enclosed.

Report No.: 50-298-79-24
Report Date: September 28, 1979
Occurrence Date: August 31, 1979
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:

Operation with an engineered safety feature instrument setting less conservative than those established in Table 3.1.1 of the Technical Specifications.

Conditions Prior to Occurrence:

The reactor was operating at a steady state power level of approximately 100% of rated thermal power.

Description of Occurrence:

While performing Surveillance Test Procedure 6.1.5, Pressure Switch NBI-PS-55D was found to trip at a setpoint higher than that allowed by Technical Specifications.

Designation of Apparent Cause of Occurrence:

The apparent cause of this occurrence was setpoint drift.

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Analysis of Occurrence:

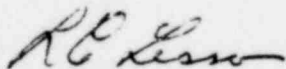
The function of pressure switch NBI-PS-55D is to monitor reactor pressure and to initiate a scram at ≤1045 psig. The switch setpoint was found to trip 8 psig above the required setpoint of 1045 psig. The redundant pressure switches NBI-PS-55A, B, & C were also tested at the time of occurrence and operated properly within Technical Specification limits. This occurrence presented no adverse consequences from the standpoint of public health and safety.

The switch was examined and no apparent cause for the setpoint drift could be found. A review of the previous calibration records revealed that this switch had also required adjustment the previous month, although it had not exceeded the Technical Specification limit at that time. The pressure switch was retested and again required readjustment. Based on this, the pressure switch was determined to be drifting excessively and was replaced.

Corrective Action:

The pressure switch was readjusted to the correct setpoint at the time of occurrence. When the switch was retested on September 9, 1979, and found to have drifted in the conservative direction, the pressure switch was replaced. The new pressure switch was calibrated and proper operation was verified by performance of Surveillance Procedure 6.1.5. The switch will be examined in an attempt to determine the cause of failure. This LER will be updated if a definite cause for the failure can be determined.

Sincerely,



L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.

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